SUMMARY OF SENATE BILL 2 AS ENACTED

The Fee

Employers of 50 or more employees are required to pay a fee for individuals working 100 hours per month or more. This requirement will also apply to employers with 20-49 employees if a tax credit meeting specified criteria is available to these employers. Employers of 200 or more are also required to pay a fee for dependants of such workers. This requirement is effective 1/1/06 for employers with 200 or more employees and 1/1/07 for employers with 50 to 199 employees.

Employers must pay at least 80% of the fee, workers no more than 20%. These fees are tied to the minimum benefits specified in the bill. However, employees with incomes below 200 percent FPL cannot pay a fee that is greater than 5% of their wages. (Employers make up the difference.) Employers may pay more than 80% of the fee and may provide other benefit packages (with greater worker contribution to the premium) as long as one of the packages complies with the requirements of the bill.

The purpose of the fee is to fund the State Health Purchasing Program (Program), a purchasing pool operated by MRMIB to fund health coverage for employees whose employers do not provide health coverage. The fees go into the State Health Purchasing Fund.

EDD is required to collect the fee from employers (employer and employee share). The fee is to be based on the number of potential enrollees on a date specified by the Board. MRMIB establishes the fee. In establishing the fee, the Board shall consider the ability of employers and enrollees to pay the fee. Employers are required to provide the Board with information on potential enrollees, as specified by the Board. The fee must fully cover the costs of the Program, including MRMIB's administrative costs and EDD's costs for collecting and enforcing the fee.

An employer can opt out of the fee by demonstrating to EDD that it provides coverage—if the coverage provided meets the minimum specified in the bill.

Benefits

For employers who wish to opt out of the fee, minimum coverage is:

- For DMHC regulatees, coverage that meets Knox-Keene requirements. In addition to HMO coverage, this includes any PPO coverage offered by a DMHC regulatee (Blue Cross/Blue Shield). For health plan contracts sold to employer groups covered by the requirements of the bill, Knox-Keene coverage is redefined to include prescription drugs.

- For insurers regulated by DOI, coverage that meets all mandates presently imposed on insurers. However, amounts for maximum out-of pocket costs can be no greater than those under Knox-Keene regulated PPOs. For insurance policies sold to employer groups covered by the requirements of the bill, Knox-Keene coverage is redefined to include prescription drugs.

- Coverage provided by a Taft-Hartley plan or other lawfully collectively bargained arrangement.

- Coverage provided under an employer-sponsored ERISA plan that meets the bill's requirements for DMHC or DOI regulatees.

- Multiple Employer Welfare Arrangements licensed by DOI if such arrangements either meet the benefit requirements for DMHC or DOI regulatees or have not changed benefits after January 1, 2004.

- Coverage provided under the Public Employees' Medical and Hospital Care Act (PEMHCA) that meets the bills' requirements for DMHC or DOI regulates.

- Health coverage provided by the University of California to students employed by the University.

Within the pool, MRMIB establishes the benefits, which must, at minimum, comply with the minimum benefit standards for employer coverage.

Market Reforms

Market reforms like those that are in place today for employers with between two and 50 employees are enacted for employers of up to 200, except that, for groups of 51-199 employees, carriers would be permitted to use greater rate bands (plus or minus 15%) to reflect groups' risk profiles and offer a different set of benefit packages from those offered to employers with 50 and fewer employees. Market rules currently in place for employer with between two and 50 employees include guarantee issue of all products, guarantee of renewal, and rate bands of plus or minus 10%. These reforms are applicable only when coverage begins to be offered through the Program.

There are no underwriting or rating reforms proposed for the market above 200.

All health care service plan contracts and health insurance policies sold to employer groups covered by the requirements of the bill must provide for the benefits and employer/employee division of costs discussed above. The carrier may also offer other products with a different employer/employee split if the employer purchasing such products is also purchasing a product that meets the requirements above.

Carriers must make reasonable efforts to contract with safety net providers. MRMIB is to contract only with carriers that can demonstrate compliance.

If the employer fee requirements in the bill are held invalid, all the market reforms discussed here become inoperative.

The Pool

The pool would be managed by MRMIB.

The pool would serve workers of employers who pay the fee to EDD. This includes employers of all sizes down to 50 employees. The pool would also serve workers of employers with 20-49 employees – and such employers would be required to pay the fee – only if a tax credit covering 20 percent of net cost were to become available.

Coverage of workers must be provided regardless of whether the employer has paid the fee for the worker.

The Board would establish required deductibles, copayment or coinsurance, including total annual out of pocket cost. The Board is to consider whether these cost sharing levels might deter enrollees from receiving appropriate and timely care, as well as the impact on employers' ability to pay the fee.

The Board is to develop and use appropriate cost containment measures and is to consider the findings of the California Health Care Quality Improvement and Cost Containment Commission established in AB 1528 of the 2003-04 Regular Session; implementation of SB 2 is contingent on enactment of AB 1528.

The Board is required to administer the program within the amount of the fees received.

Enrollment and Coordination with Other Public Programs. Employers are obligated to provide MRMIB with information on potential enrollees necessary for their enrollment. The Board also is required to obtain enrollment from potential enrollees of the Program and to notify them of the availability of Medi-Cal and Healthy Families (HFP). Potential enrollees of the Program who wish to seek enrollment in public programs such as Medi-Cal and Healthy Families may voluntarily provide the Board information on their eligibility for these programs. The Board is to obtain the information on public program eligibility from enrollees, not employers, using a "uniform enrollment form." If an enrollee volunteers such information and is found eligible for the given program (Medi-Cal or HFP), he or she shall be enrolled in that program and is to be charged any cost sharing based on the rules for the public program. The Board is to transfer sufficient funds from the employer fee to Medi-Cal or HFP to pay for the state's share of coverage costs.

Pool administration. The bill grants the Board powers like those it has under HFP. As in MRMIB's other programs, the bill provides an explicit exemption from DGS contract

review, as well as an exemption under the Public Records Act for contract negotiation strategy and (on a time-limited basis) for contracts and rates.

The bill specifies that the Board has authority and fiduciary responsibility for the administration of the program, including sole and exclusive fiduciary responsibility over the assets of the fund, sole and exclusive responsibility to administer the program to assure prompt delivery of benefits and services, and sole and exclusive responsibility over contract, budget and personnel matters.

Premium Assistance and Other Public Program Efforts

Subject to the necessary federal approvals, the Board and DHS are to develop premium assistance programs in Medi-Cal and HFP respectively, subsidizing premiums for employer-based coverage for eligible individuals and providing "wraparound" benefits. If federal approval cannot be obtained, the Board is to consult with a stakeholder group to explore alternatives to provide HFP-eligible and HFP-enrolled individuals with the same level of benefits they currently receive or are eligible to receive.

The Board is directed, within the limits of federal law, to ensure that individuals covered by or eligible for HFP retain the same level of benefits they currently are eligible to receive, including dental, vision and mental health benefits. The Board is directed to consult with a stakeholder group concerning this issue.

Additional Employer Rules

It is declared unlawful for an employer to avoid its obligations under the Act by designating an employee as an independent contractor or temporary employee or reduce employee's hours of work. An employer that does so, or that fails to pay the fee for an employee, has to pay double the fee. The pool must provide coverage for the eligible enrollee.

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